NORTH CAROLINA
BAR ASSOCIATION
HEALTH BENEFIT TRUST

REQUEST / REJECT CONTINUATION OF GROUP HEALTH COVERAGE

TO MY EMPLOYER: _____
NAME OF EMPLOYER FIRM

My employment is ending: _____
LAST DAY OF EMPLOYMENT

☐ I have been covered under the group health program for the past three months. My employment is ending and I want to continue my group health coverage for up to eighteen additional months by paying the entire fee to you, monthly, in advance.

_____ _____
EMPLOYEE'S SIGNATURE DATE SIGNED

☐ I do not want to continue my group coverage.

_____ _____
EMPLOYEE'S SIGNATURE DATE SIGNED

Name: _____

Social Security Number: _____

NOTE: EMPLOYER SHOULD SEND COPY TO

LAWYERS INSURANCE

LIA@lawyersmutualnc.com

INFORMATION AND GUIDELINES FOR COMPLETING CONTINUATION REQUEST

1. Employer should notify terminating employees that under North Carolina law, they can continue group health coverage for eighteen months. An employee is eligible only if covered under the group program for three months or longer and if written request and payment are made before group coverage terminates.
2. Employer should have the terminating employee complete this form.
3. Employer should collect the fee in advance for health coverage.
4. Employer will submit the appropriate fee at the time the regular billing statement is paid for the entire group.